

STATE OF ILLINOIS
Department of Central
Management Services
Bureau of Benefits

Benefit Choice

Discover Your Options

Benefit Choice Period • May 1-31, 2019
Local Government Health Plan
Effective July 1, 2019

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How to Elect Benefits

All Benefit Choice changes should be made on the Benefit Choice Election Form available in the Benefit Choice Flyer mailed to your home. Members should complete the form only if changes are being made. Your unit Health Plan Representative (HPR) will forward the form to the Local Government Health Plan (LGHP) for processing.

What You Need to Do

1. Continue reading this brochure to review your benefit options.
2. If you would like to make a change to your benefits this year, elect new benefits by filling out the Benefit Choice Election Form in your Benefit Choice Flyer mailed to your home or on MyBenefits.illinois.gov.
3. Give your Benefit Choice Election Form to your HPR before May 31, 2019.
4. Take advantage of your benefits which will become effective July 1, 2019.

ADDING A DEPENDENT

Dependent documentation must be submitted to your HPR by the end of the Benefit Choice Period. **If documentation is not provided within the Benefit Choice Period, your dependents will not be added.**



MARK YOUR CALENDAR

Benefit Choice Period

Elect Your Benefits May 1-31, 2019!

TAKE ACTION! Read about your benefits here,
and choose your coverage for the coming year.

What is Changing

Health Plans

All LGHP health plans will see a slight increase in copayments, coinsurance and deductibles, including prescriptions.

Out-of-Pocket

Out-of-pocket maximum levels have also increased with each of the health plans.

What is Not Changing

If you wish to keep your coverage, no action is needed. If you wish to change your plan or carrier, elect benefits by submitting a new Benefit Choice Election form to your HPR.

The MyBenefits Service Center will continue to be of service to all of our members. Members will continue to benefit from the simplified plan-comparison at MyBenefits.illinois.gov. Contact MyBenefits Service Center (toll-free) 844-251-1777, or 844-251-1778 (TDD/TTY) with questions. Representatives are available Monday - Friday, 8:00 AM - 6:00 PM CT.

Plan Administrators

Plan administrators will remain the same for all healthcare plans including health, dental, vision, behavioral health, and prescription drugs.



Health

The Local Government Health Plan offers comprehensive health plan options. Consider your health needs as you select between LCHP, LCDHP, HMO and OAP plans. Additional information about the plans listed below can be found at MyBenefits.illinois.gov.

- Local Care Health Plan (LCHP) members may choose any physician or hospital for medical services; however, members receive enhanced benefits, resulting in lower out-of-pocket costs, when receiving services from an LCHP in-network provider. LCHP has a nationwide network of medical providers through Aetna PPO.
- Local Consumer-Driven Health Plan (LCDHP) is a high-deductible health plan, which requires members to take greater responsibility for how they manage their healthcare dollars. LCDHP offers both in-network and out-of-network benefits, but using in-network providers will result in greater cost-savings. LCDHP has a nationwide network of medical providers through Aetna PPO.
- Health Maintenance Organization (HMO) members are required to stay within the health plan provider network. No out-of-network services are available. Members will need to select a primary care physician (PCP) from a network of participating providers. The PCP will direct all healthcare services and make referrals to specialists and hospitalization.
- Open Access Plan (OAP) members will have three tiers of providers from which to choose to obtain services. The benefit level is determined by the tier in which the healthcare provider is contracted.
 - Tier I offers a managed care network which provides enhanced benefits and operates similar to an HMO.
 - Tier II offers an expanded network of providers and is a hybrid plan operating similar to an HMO and PPO.
 - Tier III covers all providers which are not in the managed care networks of Tiers I or II (out-of-network providers). Using Tier III can offer members flexibility in selecting healthcare providers, but involves higher out-of-pocket costs. Furthermore, members who use out-of-network providers will be responsible for any amount that is more than the charges allowed by the plan for services (allowable charges), which could result in substantial out-of-pocket costs.

Members enrolled in an OAP can mix and match providers and tiers.



YOUR PLAN OPTIONS: A HIGH LEVEL COMPARISON

Additional health plan or prescription drug information can be viewed and compared online at MyBenefits.illinois.gov. Click the Health Plan tile on the home page.

HMO Administrators

- Aetna HMO
- BlueAdvantage HMO
- Health Alliance HMO
- HMO Illinois

OAP Administrators

- Aetna OAP
- HealthLink OAP
- *Prescription Drug Coverage through CVS/caremark*

LCHP Administrators

- Local Care Health Plan (LCHP) – Aetna
- *Prescription Drug Coverage through CVS/caremark*
- *Behavioral Health Services through Magellan Health*

LCDHP Administrators

- Local Consumer-Driven Health Plan (LCDHP) – Aetna
- *Prescription Drug Coverage through CVS/caremark*
- *Behavioral Health Services through Magellan Health*

Benefits are outlined in the plan's Summary Plan Document (SPD). It is the member's responsibility to know and follow the specific requirements of the plan. Contact the plan administrator for a copy of the SPD.

HMO Benefits

Members must select a primary care physician (PCP) from a network of participating providers. The PCP directs healthcare services and must make referrals for specialists and hospitalizations. When care and services are coordinated through the PCP, the member pays only a copayment. No plan year deductibles apply. The HMO coverage described below represents the minimum level of coverage an HMO is required to provide. Benefits are outlined in each plan's Summary Plan Document (SPD). It is the member's responsibility to know and follow the specific requirements of the HMO plan selected. Contact the plan administrator for a copy of the SPD.

HMO Plan Design	
Plan year maximum benefit	Unlimited
Lifetime maximum benefit	Unlimited
Hospital Services	
Inpatient hospitalization	100% after \$350 copayment per admission
Alcohol and substance abuse	100% after \$350 copayment per admission
Psychiatric admission	100% after \$350 copayment per admission
Outpatient surgery	100% after \$300 copayment per visit
Diagnostic lab and x-ray	100%
Emergency room hospital services	100% after \$300 copayment per visit
Professional and Other Services (Copayment not required for preventive services)	
Physician Office visit	100% after \$40 copayment per visit
Preventive Services, including immunizations	100%
Specialist Office visit	100% after \$45 copayment per visit
Well Baby Care (first year of life)	100%
Outpatient Psychiatric and Substance Abuse	100% after \$40/\$45 copayment per visit
Prescription drugs (30-day supply) \$175 deductible per enrollee (formulary is subject to change during plan year)	\$15 copayment for generic \$30 copayment for preferred brand \$60 copayment for nonpreferred brand \$120 copayment for specialty
Durable Medical Equipment	70%
Home Health Care	\$45 copayment per visit

Some HMOs may have benefit limitations based on a calendar year.

Open Access Plan (OAP) Benefits

The benefits described below represent the minimum level of coverage available in an OAP. Benefits are outlined in the plan's Summary Plan Document (SPD). It is the member's responsibility to know and follow the specific requirements of the OAP plan. Contact the plan administrator for a copy of the SPD.

Benefit	Tier I 100% Benefit	Tier II 80% Benefit	Tier III (Out-of-Network)** 50% Benefit
Plan Year Maximum Benefit	Unlimited	Unlimited	Unlimited
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Plan Year Out-of-Pocket Maximum Per Individual Enrollee Per Family	\$7,250 (includes eligible charges from Tier I and Tier II combined) \$13,750 (includes eligible charges from Tier I and Tier II combined)		Not Applicable
Plan Year Deductible (must be satisfied for all services)	\$0	\$400 per enrollee*	\$600 per enrollee*
Hospital Services			
Inpatient	100% after \$350 copayment per admission	80% of network charges after \$400 copayment per admission	50% of allowable charges after \$500 copayment per admission
Inpatient Psychiatric	100% after \$350 copayment per admission	80% of network charges after \$400 copayment per admission	50% of allowable charges after \$500 copayment per admission
Inpatient Alcohol and Substance Abuse	100% after \$350 copayment per admission	80% of network charges after \$400 copayment per admission	50% of allowable charges after \$500 copayment per admission
Emergency Room	100% after \$300 copayment per visit	100% after \$300 copayment per visit	100% after \$300 copayment per visit
Outpatient Surgery	100% after \$300 copayment per visit	80% of network charges after \$300 copayment	50% of allowable charges after \$300 copayment
Diagnostic Lab and X-ray	100%	80% of network charges	50% of allowable charges
Physician and Other Professional Services (Copayment not required for preventive services)			
Physician Office Visits	100% after \$40 copayment	80% of network charges	50% of allowable charges
Specialist Office Visits	100% after \$45 copayment	80% of network charges	50% of allowable charges
Preventive Services, including immunizations	100%	100%	Covered under Tier I and Tier II only
Well Baby Care (first year of life)	100%	100%	Covered under Tier I and Tier II only
Outpatient Psychiatric and Substance Abuse	100% after \$40/\$45 copayment	80% of network charges	50% of allowable charges
Other Services			
Prescription Drugs – Copayments (30-day supply) \$175 deductible per enrollee			
Generic \$15 Preferred Brand \$30 Nonpreferred Brand \$60 Specialty \$120			
Durable Medical Equipment	70% of network charges	60% of network charges	50% of allowable charges
Skilled Nursing Facility	85% of network charges	85% of network charges	Covered under Tier I and Tier II only
Transplant Coverage	100%	90% of network charges	Covered under Tier I and Tier II only
Home Health Care	100% after \$45 copayment	75% of network charges	Covered under Tier I and Tier II only

* A plan year deductible must be met before Tier II and Tier III plan benefits apply. Benefit limits are measured on a plan year basis.

** Using out-of-network services may significantly increase your out-of-pocket expense. Amounts over the plan's allowable charges do not count toward your plan year out-of-pocket maximum; this varies by plan and geographic region. Members who use out-of-network providers, should contact their health plan administrator for information regarding out-of-network changes before obtaining services.

Local Care Health Plan (LCHP) Benefits - Aetna

Plan Year Maximums and Deductibles			
Plan Year Maximum		Unlimited	
Lifetime Maximum		Unlimited	
Plan Year Deductible		\$1,000 per enrollee	
Additional Deductibles*		Each emergency room visit	\$400
		LCHP hospital admission	\$350
		Non-LCHP hospital admission	\$600
		Transplant deductible	\$250
Out-of-Pocket Maximum Limits			
In-Network Individual \$2,000	In-Network Family \$4,000	Out-of-Network Individual \$6,000	Out-of-Network Family \$12,000
The plan has two out-of-pocket maximums, one for all eligible in-network services and one for all eligible out-of-network services. Each out-of-pocket maximum (in-network vs. out-of-network) is exclusive and separate from the other. Plan medical and prescription drug coinsurance and medical deductibles apply toward the out-of-pocket maximums. Out-of-network benefits will be paid at 100% up to the allowable charges after the applicable out-of-pocket maximum has been met. In-network benefits will be paid at 100% of the charges after the applicable out-of-pocket maximum has been met.			
Hospital Services			
LCHP Hospital Network		\$350 deductible per hospital admission. 80% after the plan year deductible.	
Non-LCHP Hospitals**		\$600 deductible per hospital admission. 50% of allowable charges after the plan year deductible.	
Outpatient Services			
Preventive Services, including immunizations		100% in-network. After the plan year deductible, 50% of allowable charges out-of-network.**	
Diagnostic Lab/X-ray		80% in-network. After the plan year deductible, 50% of allowable charges out-of-network.**	
Approved Durable Medical Equipment (DME) and Prosthetics			
Licensed Ambulatory Surgical Treatment Centers			
Professional and Other Services			
Services included in the LCHP Network		80% after the plan year deductible.	
Services not included in the LCHP Network**		50% of allowable charges after the plan year deductible.	
Chiropractic Services – medical necessity required (up to a maximum of 30 visits per plan year)		80% in-network. After the plan year deductible, 60% of allowable charges out-of-network.**	
Transplant Services			
Organ and Tissue Transplants	\$250 transplant deductible, 90% after the plan year deductible, limited to network transplant facilities as determined by the medical plan administrator. Benefits are not available unless approved by the Notification Administrator, Aetna. To assure coverage, the transplant candidate must contact Aetna prior to beginning evaluation services.		
Prescription Drugs (\$175 deductible per enrollee)			
Copayments (30-day supply)	Generic	\$15.00	
	Preferred Brand	\$30.00	
	Nonpreferred Brand	\$60.00	
	Specialty	\$120.00	

* These are in addition to the plan year deductible.

** Using out-of-network services may significantly increase your out-of-pocket expense. Amounts over the plan's allowable charges do not count toward your plan year out-of-pocket maximum; this varies by plan and geographic region. Members who use out-of-network providers, should contact their health plan administrator for information regarding out-of-network changes before obtaining services.

Local Consumer-Driven Health Plan (LCDHP) - Aetna

Plan Year Maximums and Deductibles			
Plan Year Maximum		Unlimited	
Lifetime Maximum		Unlimited	
Plan Year Deductible		In-Network	Out-of-Network**
– Individual		\$2,000	\$4,000
– Family		\$4,000	\$8,000
Out-of-Pocket Maximum Limits			
In-Network Individual \$5,000	In-Network Family \$8,000	Out-of-Network Individual \$7,000	Out-of-Network Family \$14,000

The plan has two out-of-pocket maximums, one for all eligible in-network services and one for all eligible out-of-network services. Each out-of-pocket maximum (in-network vs. out-of-network) is exclusive and separate from the other. Plan medical and prescription drug coinsurance and medical deductibles apply toward the out-of-pocket maximums. Out-of-network benefits will be paid at 100% up to the allowable charges after the applicable out-of-pocket maximum has been met. In-network benefits will be paid at 100% of the charges after the applicable out-of-pocket maximum has been met.

Hospital Services	
LCDHP Hospital Network	80% after the plan year deductible.
Non-LCDHP Hospitals**	50% after the plan year deductible.

Outpatient Services	
Preventive Services, including immunizations	100% covered in-network only
Diagnostic Lab/X-ray	80% in-network. After the plan year deductible, 50% of allowable charges out-of-network.**
Approved Durable Medical Equipment (DME) and Prosthetics	
Licensed Ambulatory Surgical Treatment Centers	

Professional and Other Services	
Services included in the LCDHP Network	80% after the plan year deductible.
Services not included in the LCDHP Network**	50% of allowable charges after the plan year deductible.
Chiropractic Services – medical necessity required (up to a maximum of 30 visits per plan year)	80% in-network. After the plan year deductible, 50% of allowable charges out-of-network.**

Transplant Services	
Organ and Tissue Transplants	90% after the plan year deductible, limited to network transplant facilities as determined by the medical plan administrator. Benefits are not available unless approved by the Notification Administrator, Aetna. To assure coverage, the transplant candidate must contact Aetna prior to beginning evaluation services.

Prescription Drugs			
Preventive Prescription Drugs		Applicable coinsurance; not subject to plan year deductible.	
Prescription Drugs (30-day supply)	Generic	70%	
	Preferred Brand	50%	
	Nonpreferred Brand	50%	

* For members who have at least one dependent, the family deductible must be met before any family member can receive coverage at the plan's benefit levels of 80% (in-network) and 50% (out-of-network).

** Using out-of-network services may significantly increase your out-of-pocket expense. Amounts over the plan's allowable charges do not count toward your plan year out-of-pocket maximum; this varies by plan and geographic region. Members who use out-of-network providers, should contact their health plan administrator for information regarding out-of-network changes before obtaining services.

Health Plan Comparison

Benefit	LCHP		LCDHP		HMO	OAP Tier I (in-network)	OAP Tier II (in-network)	OAP Tier III (out-of-network**)
Patient Responsibilities								
Annual Out-of-Pocket Maximum	In-Network	Out-of-Network	In-Network	Out-of-Network				
	\$2,000	\$6,000	\$5,000	\$7,000	\$3,000	\$7,250 (Tier I and Tier II combined)		Not applicable
Per Enrollee	\$4,000	\$12,000	\$8,000	\$14,000	\$6,000	\$13,750 (Tier I and Tier II combined)		Not applicable
Per Family								
Plan Year Deductible*								
Per Enrollee	\$1,000 per enrollee		\$2,000	\$4,000	Not applicable	Not applicable	\$400 per enrollee	\$600 per enrollee
Per Family	\$1,000 per enrollee		\$4,000	\$8,000			\$400 per enrollee	\$600 per enrollee
Plan Benefit Levels Comparison								
Annual Out-of-Pocket Maximum	In-Network	Out-of-Network**	In-Network	Out-of-Network**				
Emergency Room	80% after \$400 ER deductible*	80% after \$400 ER deductible*	80%*	80%*	\$300	\$300	\$300	\$300
Preventive Services including immunizations	100%	50% of allowable charges*	100%	No coverage	100%	100%	100%	Covered under Tier I and Tier II only
Inpatient	80% of network charges after \$350 per visit*	50% of allowable charges after \$600 per visit*	80% of network charges*	50% of allowable charges*	\$350 copayment	\$350 copayment	80% of network charges* after \$400 copayment	50% of allowable charges* after \$500 copayment
Outpatient Surgery	80% of network charges*	50% of allowable charges*	80% of network charges*	50% of allowable charges*	\$300 copayment	\$300 copayment	80% of network charges* after \$300 copayment	50% of allowable charges* after \$300 copayment
Diagnostic Lab and X-ray	80% of network charges*	50% of allowable charges*	80% of network charges*	50% of allowable charges*	100%	100%	80% of network charges*	50% of allowable charges*
Durable Medical Equipment	80% of network charges*	50% of allowable charges*	80% of network charges*	50% of allowable charges*	70% of network charges	70% of network charges	60% of network charges*	50% of allowable charges*
Physician Office Visit	80% of network charges*	50% of allowable charges*	80% of network charges*	50% of allowable charges*	\$40 copayment	\$40 copayment	80% of network charges*	50% of allowable charges*

* The plan year deductible must be met before benefit levels will be applied.

** Using out-of-network services may significantly increase your out-of-pocket expense. Amounts over the plan's allowable charges do not count toward your plan year out-of-pocket maximum; this varies by plan and geographic region. Members who use out-of-network providers should contact their health plan administrator for information regarding out-of-network charges before obtaining services.

Out-of-Pocket Maximum

After the out-of-pocket maximum has been satisfied, the plan will pay 100 percent of covered expenses for the remainder of the plan year. Charges that apply toward the out-of-pocket maximum for each type of plan varies and are outlined in the chart below.

In accordance with the Affordable Care Act (ACA), prescription coinsurance and copayments paid by members will also apply toward the out-of-pocket maximum; therefore, once the out-of-pocket maximum has been met, eligible medical, behavioral health and prescription drug charges will be covered at 100 percent for the remainder of the plan year.

The following are the types of charges that apply to the out-of-pocket maximum by plan type:

- **Local Care Health Plan:***
 - Medical plan year deductible
 - Prescription copayments
 - Medical coinsurance
 - LCHP additional medical deductibles
- **Local Consumer-Driven Health Plan:***
 - Medical plan year deductible
 - Medical and prescription coinsurance

** Eligible charges for in-network and out-of-network services will accumulate separately and will not cross accumulate.*

- **HMO Plans:**
 - Medical and prescription copayments
 - Medical coinsurance
- **OAP Plans (only applies to Tier I and Tier II providers):**
 - Medical plan year deductible (Tier II)
 - Medical and prescription copayments
 - Medical coinsurance

Eligible charges from Tiers I and II will be added together when calculating the out-of-pocket maximum. **Tier III does not have an out-of-pocket maximum.**

Certain charges are always the member's responsibility and do not count toward the out-of-pocket maximum, nor are they covered after the out-of-pocket maximum has been met. Charges that do not count toward the out-of-pocket maximum include:

- The dispense as written (DAW) penalty (i.e., the cost difference between a brand name medication and a generic, plus the brand copayment when a generic is available);
- Amounts over allowable charges (MRC, MAC, U+C**) for the plan;
- Noncovered services;
- Charges for services deemed to be not medically necessary; and
- Penalties for failing to precertify/provide notification.

CHARGES THAT APPLY TOWARD OUT-OF-POCKET MAXIMUM						
PLAN	Out-of-Pocket Maximum Limits	Plan Year Deductible	Additional Deductibles (LCHP)/ Copayments	Medical Coinsurance	Pharmacy Coinsurance/ Copayments/ Deductible	Amounts over Allowable Charges (LCHP and LCDHP out-of-network providers and OAP Tier III providers)
LCHP	In-Network Individual \$2,000 Family \$4,000	X	X	X	X	Amounts over the plan's allowable charges (MRC, MAC, U+C**) are the member's responsibility and do not go toward the out-of-pocket maximum.
	Out-of-Network Individual \$6,000 Family \$12,000	X	X	X	X	
LCDHP	In-Network Individual \$5,000 Family \$8,000	X	N/A	X	X	
	Out-of-Network Individual \$7,000 Family \$14,000	X	N/A	X	X	
HMO	Individual \$3,000 Family \$6,000	N/A	X	X	X	
OAP Tier I	Individual \$7,250 Family \$13,750	X	X	X	X	
OAP Tier II	Tiers I and Tier II charges combined	X	X	X	X	
OAP Tier III	N/A	N/A	N/A	N/A	N/A	

Note: Eligible charges for medical, behavioral health and prescription drugs that the member pays toward the plan year deductibles, as well as plan copayments and/or coinsurance will be added together for the out-of-pocket maximum calculation. OAP Tier III does not have an out-of-pocket maximum. MRC** = Maximum Reimbursable Charge, MAC = Maximum Allowable Charge, U+C = Usual and Customary



State of Illinois
Medicare COB Unit
PO Box 19208
Springfield, IL 62794-9208
Fax: 217-557-3973

Qualifying Changes in Status

After the Benefit Choice Period ends, you will only be able to change your benefits if you have a qualifying change in status.

You must report a qualifying change in status to your Health Plan Representative (HPR) within 60 days of the event to be eligible to make benefit changes outside of the Benefit Choice Period. The change will be effective the date of the event or request, whichever is later. Also note that it is required to report important events to your HPR, including a change in Medicare status, leave of absence, unpaid time away from work, or to report a financial or medical power of attorney.

Transition of Care after Health Plan Change

Members and their dependents who elect to change health plans and are then hospitalized prior to July 1 and discharged on or after July 1, should contact both the current and future health plan administrators and primary care physicians as soon as possible to coordinate the transition of services.

Members or dependents who are involved in an ongoing course of treatment or have entered the third trimester of pregnancy, should contact their new plan administrator before July 1 to coordinate the transition of services for treatment.

Local Government Health Plan

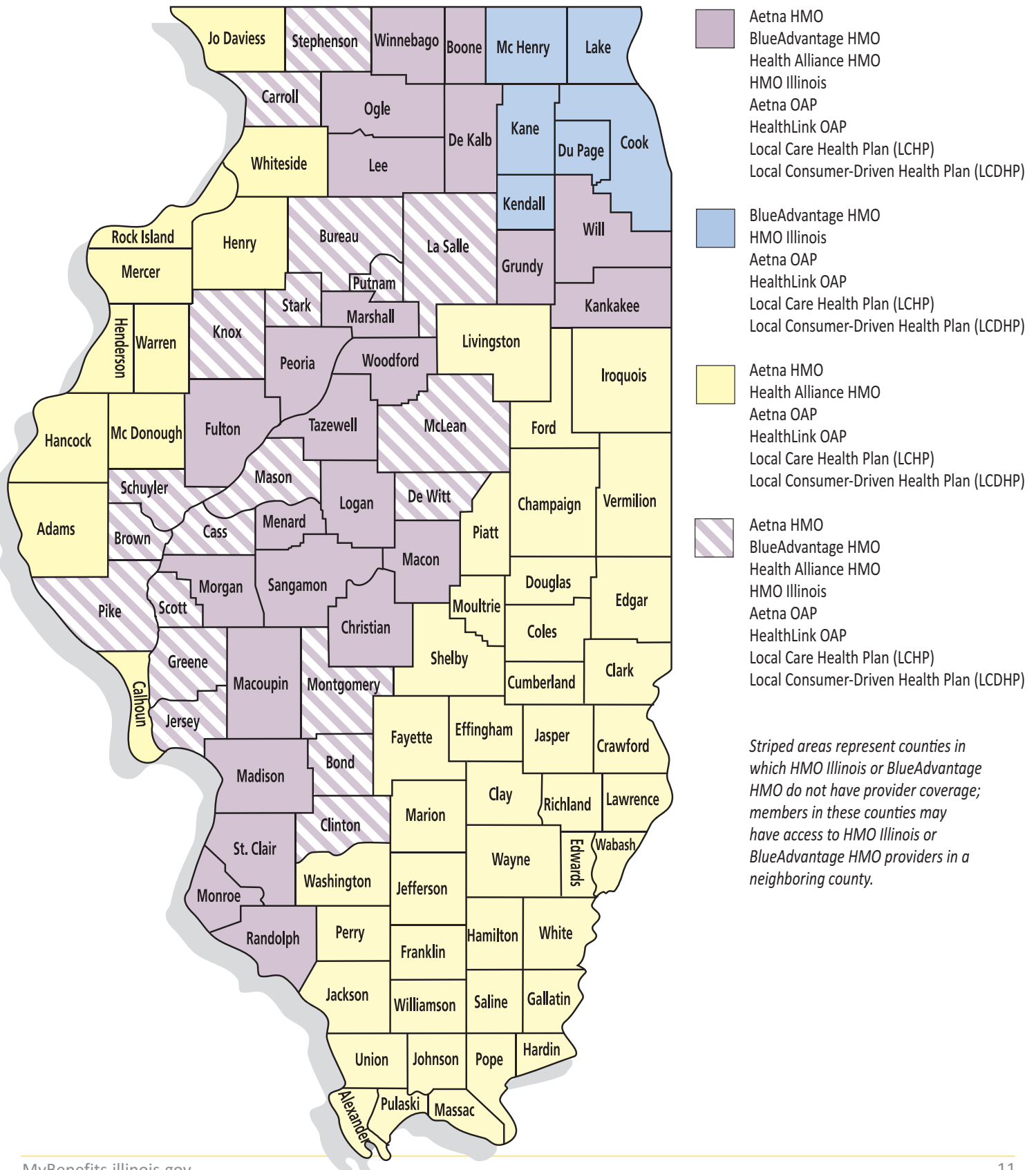
Medicare Requirements

Each member and dependent must contact the Social Security Administration (SSA) and apply for Medicare benefits upon turning age 65. If the SSA determines that the member is eligible for Medicare Part A at a premium-free rate, the member is required by the LGHP to enroll in Medicare Part A. Once enrolled in Medicare, the member and/or dependent is required to send a front-side copy of the Medicare identification card to the State of Illinois Medicare COB Unit.

If the SSA determines that a member is not eligible for premium-free Medicare Part A based on his/her own work history or the work history of a spouse at least 62 years of age (when applicable), the member must request a written statement of the Medicare ineligibility from the SSA. Upon receipt, the written statement must be forwarded to the State of Illinois Medicare COB Unit to avoid a financial penalty.

What is Available in Your Area in FY20

Review the following map and charts to compare plans. Then, review your out-of-pocket maximums to determine which plan is best for you.





Dental

The Local Care Dental Plan (LCDP) offers a comprehensive range of benefits and is available to all members. The plan is administered by Delta Dental of Illinois. You can find the Dental Schedule of Benefits at [MyBenefits.illinois.gov](https://mybenefits.illinois.gov). The dental plan has a plan year deductible. Once the deductible has been met, each member is subject to a maximum dental benefit, including orthodontia, for both in-network and out-of-network providers

Deductible and Plan Year Maximum

Plan year deductible for preventive services	N/A
Plan year deductible for all other covered services	\$100
Plan Year Maximum Benefit (Orthodontics + All Other Covered Expenses = Maximum Benefit)	
Plan year maximum benefit per person	\$2,000

It is strongly recommended that plan members obtain a pretreatment estimate through Delta Dental for any service over \$200. Failure to obtain a pretreatment estimate may result in unanticipated out-of-pocket costs.

Child Orthodontia Benefit

Length of Orthodontia Treatment	Maximum Benefit
0 - 36 Months	\$1,500
0 - 18 Months	\$1,364
0 - 12 Months	\$780

Vision

Vision coverage is provided to all members enrolled in the LGHP. The plan is administered by EyeMed. All enrolled members and dependents receive the same vision coverage regardless of the health plan selected. Copayments are required.

Service	In-Network	Out-of-Network**	Benefit Frequency
Eye Exam	\$25 copayment	\$30 allowance	Once every 12 months
Spectacle Lenses* (single, bifocal and trifocal)	\$25 copayment	\$50 allowance for single vision lenses \$80 allowance for bifocal and trifocal lenses	Once every 12 months
Standard Frames	\$25 copayment (up to \$175 retail frame cost; member responsible for balance over \$175)	\$70 allowance	Once every 24 months
Contact Lenses (All contact lenses are in lieu of spectacle lenses)	\$120 allowance	\$120 allowance	Once every 12 months

* Spectacle Lenses: Member pays any and all optional lens enhancement charges. In-network providers may offer additional discounts on lens enhancements and multiple pair purchase.

** Out-of-network claims must be filed within one year from the date of service.





Wellness

LGHP offers wellness programs to help members lead better, healthier, and more satisfying lives. The following programs focus on improving lifestyle choices, including eating healthier, being more physically active, managing stress, and avoiding, stabilizing, or improving chronic health problems. Check out the following programs and consider which may be right for you.

WHAT YOU CAN DO

- 1. Get annual preventive checkups and health screenings.** Your health plan covers many preventive services at no cost to you.
- 2. Know your numbers.** Get biometric screenings from your doctor during your annual physical – quick and easy tests that measure your blood pressure, pulse rate, blood glucose, total cholesterol, and body mass index.
- 3. Take a Health Risk Assessment (HRA)** through your health plan administrator's website – a confidential assessment with health-related questions that, once completed, suggests a personal action plan to improve your health. Results are most accurate when combined with a biometric screening.

Disease Management

Disease Management Programs target and assist those identified as having certain risk factors for chronic conditions, like diabetes and cardiac health. If you have been identified as having risk factors and meet the appropriate medical criteria, you may be contacted by your health plan administrator to participate in one of these highly confidential programs.

Behavioral Health Services

LGHP recognizes that the holistic health of their members encompasses more than physical health, and offers behavioral health services automatically to those enrolled in a LGHP health plan.

If you are enrolled in the LCHP or the LCDHP, contact Magellan Health (see page 15). If you are enrolled in an HMO or OAP health plan, contact your plan administrator.

Contacts

Purpose	Administrator Name and Address	Phone	Website
Enrollment Customer Service	MyBenefits – Morneau Shepell 134 N. LaSalle Street, Suite 2200, Chicago, IL 60602	844-251-1777 844-251-1778 (TDD/TTY)	MyBenefits.illinois.gov
Health Plan	Aetna HMO (Group Number 285656) PO Box 981106, El Paso, TX 79998-1106	855-339-9731 800-628-3323 (TDD/TTY)	aetnastateofillinois.com
	Aetna OAP (Group Number 285652) PO Box 981106, El Paso, TX 79998-1106	855-339-9731 800-628-3323 (TDD/TTY)	aetnastateofillinois.com
	Local Care Health Plan (LCHP) - Aetna PPO (Group Number 285661) PO Box 981106, El Paso, TX 79998-1106	855-339-9731 800-628-3323 (TDD/TTY)	aetnastateofillinois.com
	Local Consumer-Driven Health Plan (LCDHP) - Aetna PPO (Group Number 285661) PO Box 981106, El Paso, TX 79998-1106	855-339-9731 800-628-3323 (TDD/TTY)	aetnastateofillinois.com
	BlueAdvantage HMO (Group Number B06801) PO Box 805107, Chicago, IL 60680-4112	800-868-9520 866-876-2194 (TDD/TTY)	bcbsil.com/stateofillinois
	Health Alliance Medical Plans (Group Number 000610) 3310 Fields South Drive, Champaign, IL 61822	800-851-3379 800-526-0844 (TDD/TTY)	healthalliance.org/ stateofillinois
	HealthLink OAP (Group Number 160001) PO Box 411580, St. Louis, MO 63134	800-624-2356 800-624-2356 ext. 6280 (TDD/TTY)	healthlink.com/illinois_ index.asp
	HMO Illinois (Group Number H06801) PO Box 805107, Chicago, IL 60680-4112	800-868-9520 866-876-2194 (TDD/TTY)	bcbsil.com/stateofillinois
Prescription Drug Plan	CVS/caremark (for LCHP, LCDHP or OAP) Group Numbers: (LCHP 1401LD3) (LCDHP 1401LD9) (Aetna OAP 1401LCH) (HealthLink OAP 1401LCF) Paper Claims: CVS/caremark PO Box 52136, Phoenix, AZ 85072-2136 Mail Order Rx: CVS/caremark PO Box 94467, Palatine, IL 60094-4467	877-232-8128 800-231-4403 (TDD/TTY)	caremark.com
Vision Plan	EyeMed Out-of-Network Claims PO Box 8504, Mason, OH 45040-7111	866-723-0512 866-308-5375 (TDD/TTY)	eyemedvisioncare.com/stil
Dental Plan	Delta Dental of Illinois (Group Number 20241) PO Box 5402, Lisle, IL 60532	800-323-1743 800-526-0844 (TDD/TTY)	soi.deltadentalil.com
Behavioral Health	Magellan Health PO Box 2216, Maryland Heights, MO 63043	800-513-2611 (nationwide) 800-456-4006 (TDD/TTY)	magellanassist.com

Federally Required Notices

Notice of Creditable Coverage

Prescription Drug information for LGHP Medicare-eligible Plan Participants

This Notice confirms that the Local Government Health Plan (LGHP) has determined that the prescription drug coverage it provides is Creditable Coverage. This means that the prescription coverage offered through LGHP is, on average, as good as, or better than the standard Medicare prescription drug coverage (Medicare Part D). You can keep your existing group prescription coverage and choose not to enroll in a Medicare Part D plan.

Because your existing coverage is Creditable Coverage, you will not be penalized if you later decide to enroll in a Medicare prescription drug plan. However, you must remember that if you drop your coverage through LGHP and experience a continuous period of 63 days or longer without Creditable Coverage, you may be penalized if you enroll in a Medicare Part D plan later. If you choose to drop your LGHP coverage, the Medicare Special Enrollment Period for enrollment into a Medicare Part D plan is two months after your LGHP coverage ends.

If you keep your existing group coverage through LGHP, it is not necessary to join a Medicare prescription drug plan this year. Plan participants who decide to enroll in a Medicare prescription drug plan may need to provide a copy of the Notice of Creditable Coverage to enroll in the Medicare prescription plan without a financial penalty. Participants may obtain a Benefits Confirmation Statement as a Notice of Creditable Coverage by contacting the MyBenefits Service Center (toll-free) 844-251-1777, or 844-251-1778 (TDD/TTY).

Summary of Benefits and Coverage (SBC) and Glossary

Under the Affordable Care Act, health insurance issuers and group health plans are required to provide you with an easy-to-understand summary about a health plan's benefits and coverage. The summary is designed to help you better understand and evaluate your health insurance choices.

The forms include a short, plain language Summary of Benefits and Coverage (SBC) and a glossary of terms commonly used in health insurance coverage, such as "deductible" and "copayment."

All insurance companies and group health plans must use the same standard SBC form to help you compare health plans. The SBC form also includes details, called "coverage examples," which are comparison tools that allow you to see what the plan would generally cover in two common medical situations. You have the right to receive the SBC when shopping for, or enrolling in coverage, or if you request a copy from your issuer or group health plan. You may also request a paper copy of the SBCs and glossary of terms from your health insurance company or group health plan. All LGHP health plan SBCs are available on [MyBenefits.illinois.gov](https://mybenefits.illinois.gov).

Notice of Privacy Practices

The Notice of Privacy Practices will be updated at [MyBenefits.illinois.gov](https://mybenefits.illinois.gov), effective July 1, 2019. You have a right to obtain a paper copy of this Notice, even if you originally obtained the Notice electronically. We are required to abide by the terms of the Notice currently in effect; however, we may change this Notice. If we materially change this Notice, we will post the revised Notice on our website at [MyBenefits.illinois.gov](https://mybenefits.illinois.gov).

Notes



Illinois Department of Central Management Services
Bureau of Benefits
PO Box 19208
Springfield, IL 62794-9208